King County Asthma Forum

Section 6 - Increased coordination among schools, clinics, childcare settings, and managed care plans and implementation of policies that impact systems of care

(Updated through March 2004)

Objective: **Increased coordination among schools, clinics, childcare settings, and managed care plans and implementation of policies that impact systems of care**

Strategic Area: **Improving coordination across levels**

Description

Allies Against Asthma (AAA) is carrying out a number of activities to increase coordination of care across organizations that care for and educate children, including:

- **Development of explicit referral protocols across levels.** For example, clinicians and school nurses will refer children to Community Health Workers (CHWs), parents may request assistance from their childcare provider, school administrators may request assistance in the school setting, or community members may ask for educational materials or be referred to other asthma services depending upon their need. In late 2002 the Cross Project Coordination (CPC) group was formed and meets bi-monthly to systematically coordinate communication, recruitment, referrals, and triage to asthma services. Members include representatives from call core and sponsored forum projects and any other organizations that wish to coordinate their services with others. The CPC provides a venue for potentially competing organizations to collaborate on the delivery of their services and they also coordinate the consistency of asthma messages. They established an asthma triage phone line in three languages (Vietnamese, Spanish, and English) to facilitate access to services and developed protocols for referrals to facilitate access to asthma services in King County. The bulk of cross-referrals will be managed by CHWs, the Asthma Management Coordinator (AMC), and the Community Organizer/Health Educator.
- **Development of a common asthma action plan for use by schools, clinics, community health workers and childcare sites.** A common action plan was developed in consultation with asthma champions, CHWs, school liaisons, and KCAF member organizations. KCAF strongly encourage all participants in the high intensity intervention to use the chosen form. The form is available on the KCAF website and has been distributed to stakeholders in the AAA target area including schools, clinics and individuals.
- **Development of common educational resources to promote delivery of consistent, reinforcing health education messages.** Health educators, providers, and other Forum members are reviewing a variety of educational materials and will choose the best to be presented to the KCAF Clinical and Neighborhood committees for review and selection of recommended materials. These will then be purchased or reproduced and distributed to all CHWs, clinics, school nurses, pharmacies, childcare sites and interested community members and organizations in the AAA target area (and more widely in King County, as funds permit)
- **Promoting a consistent and unified approach to asthma from the child and caretaker perspectives.** CHWs and the AMC help clients obtain clear and consistent asthma information and action plans by working with them and their service providers to reconcile inconsistencies. Once a child participates in any AAA-related activity, we work with his or her school, childcare site or medical provider, regardless of whether the service provider is a primary AAA participant. In this way, we begin to coordinate and increase awareness beyond our targeted areas.

Progress

The primary process measures for increased coordination involve the development and use of a common asthma action plan and educational resources, types of communication systems that are developed, degree of communication across various sectors of the community. Outcome measures for increased coordination are around a reduction in inappropriate health care services.

Process Measures

Process objective	*Status/Indicators*	*Next Steps*
Development and adoption of common action plan by relevant institutions	• Adopted January 2003 • # institutions using plan?	
Action plans are in use	• # families with plan • # families with plan in home, school, childcare, health care provider	• Waiting for data
Development and use of common educational resources by relevant institutions	• Date of adoption • # institutions using resources	• Waiting for data
Care is coordinated and community members are referred to appropriate resources	• Over 50 families with care coordinated by Asthma Mgt Coordinator, Community Health Workers, and Outreach Coordinator • 113 callers were referred to KCAF programs and other community resources through triage phone line	
Communication is occurring across sectors and among asthma projects	• KCAF Cross project coordination committee meets bi-monthly • Communication systems in place • Degree and frequency of communication • Parent are satisfied with coordination efforts	• Continue developing communication systems with schools

Outcome Measures

Outcome objective	*Status/Indicators*	*Next Steps*
Reduction in inappropriate use of health care system	• Reduction in use of ED and hospitals • Reduction in rescue medication refills • Increased number of planned visits	• Waiting for data

Success, Challenges, Lessons Learned

Successes:

- **A range of service providers** have committed to coordinating care.
- **Communication systems have been developed** for coordination among CHW client's, clinics, childcare sites, and schools.
- **A triage line was set up** for responding to requests for services.
- **A Cross Project Coordination group was formed** to coordinate communication, recruitment, referrals, and triage to asthma services.
- **CHWs and the AMC are creating linkages** between providers, school nurses, childcare providers and community resources.

Challenges:

- **Some groups are using their own action plans** and are unwilling/not able to use the common plan. It was not feasible to achieve the original Steering Committee goal of having one common action plan in place and used uniformly across levels. The goal was revised that allowed for different plans to be used.
- **HIPAA and IRB restrictions complicated and impede** the ease of care coordination.
- **It is difficult and cumbersome to track all case management events**
- **Cross Project Coordination efforts are very time-intensive** and often require individuals to set aside their organizational agendas for the benefit of the collaboration.

Lessons Learned:

- **The level of coordination that is being pursued would not be possible without the input of coalition members** whose backgrounds and experiences provide the variety of perspectives necessary for success.
- **Having a key coordinating body** facilitates the development of a system.
- **Ongoing, sophisticated communication systems are critical** for this level of coordination.
- **On an individual level, care coordination resolves a lot of gaps in care.** We already have a number of examples of how care was improved!